Agenda Item 1
1/24/07 Meeting

Managed Risk Medical Insurance Board
December 20, 2006

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Virginia Gotlieb, M.P.H., Sophia Chang, M.D., M.P.H., Richard Figueroa, M.B.A
Ex Officio Members Present:	Warren Barnes (for Ed Heidig), Bob Sands (for Joe Munso), Jack Campana
Staff Present:	Lesley Cummings, Laura Rosenthal, Denise Arend, Janette Lopez, Glenn Hair, Ruth Jacobs, Terresa Krum, Ronald Spingarn, Mary Anne Terranova, Ernesto Sanchez, Larry Lucero, Kathy Dobrinen, Carolyn Tagupa, Ruben Mejia, Rose Lamb, Sarah Swaney, Thien Lam, Adrienne Thacker, Anne Marie Terranova

Chairman Allenby called the meeting to order and recessed it for executive session. At the conclusion of executive session, the meeting was reconvened.

Chairman Allenby took a moment to introduce and welcome Ronald Spingarn, the Deputy Director of Legislation and External Affairs of MRMIB. Mr. Spingarn gave a brief overview of his professional experience.

Chairman Allenby thanked Mr. Spingarn. Ms. Cummings then introduced and welcomed Terresa Krum, the new Deputy Director of Administration for MRMIB. Ms. Krum gave a brief overview of her professional experience.

REVIEW AND APPROVAL OF MINUTES OF November 15, 2006 MEETING

The Board reviewed the minutes. Mr. Campana noted that on page 5, last paragraph regarding the issue of mental health assessment and zero tolerance, the sentence should be revised as follows: “should have a mental health assessment as part of an expulsion process. “

A motion was made and unanimously passed to approve the minutes of the November 15, 2006, meeting as revised.

STATE LEGISLATION UPDATE

Mary Anne Terranova provided the Board with an update of bills that affect MRMIB's programs. She particularly commented on bills introduced that would expand health coverage for children. AB 1 (Dymally) would create the California Healthy Children Insurance Program, to be operated jointly by Department of Health Care Services (previously DHS) and the Healthy Families Program. AB 13 (Laird), still under development, would also expand coverage. It is sponsored by the 100% Campaign and People Improving Communities by Organizing, otherwise known as PICO. SB 32 (Steinberg) is also sponsored by the 100% Campaign and PICO.

Next, Ms. Terranova reviewed the bills aimed at health care reform. She discussed AB 53 (Dymally), AB 75 (Blakeslee), AB 30 (Evans) and AB 56 (Alarcon).

Ms. Terranova then discussed the MRMIP bill, AB 2 (Dymally). This bill essentially is AB 1971 (Chan) from the last session. The bill would establish a funding mechanism to fully fund the Major Risk Medical Insurance Program by requiring health plans and insurers to either participate in the program, or pay a fee based on the covered lives.

Chairman Allenby asked if there were any questions or comments. There were none.

Ronald Spingarn commented on some major health reform initiatives not yet in bill form. He noted that the Governor has labeled 2007 "the year of health care". The Governor's proposal will be released on January 9 in the State of the State address. Senator Perata held a press conference on December 12th announcing that he would author a major reform proposal. The proposal, not yet in bill form, would be an employer-based pay or play approach that will cover approximately 64 percent of the uninsured people in the state through employers.
It would also increase the Healthy Families requirements from 250 percent to 300 percent of FPL. This would increase the number of children insured through the Healthy Families program. Mr. Spingarn then discussed the large role MRMIB would play under the proposal, which includes establishing and managing a purchasing pool.

Mr. Spingarn also stated Senator Kuehl plans to re-introduce a single payor universal health care bill. Ms. Cummings indicated that she will be a co-author of Senator Perata's bill as well.

Chairman Allenby asked if there were any questions or comments. Mr. Figueroa stated the Assembly Speaker will be announcing his own health care reform plan on December 21, 2006.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Reports

Ernesto Sanchez reviewed the monthly enrollment reports. As of November 30, 2006, 777,317 children were enrolled. There were no major shifts in demographics of ethnicity or gender. The number of applications coming through the single point of entry assisted by CAA's increased slightly to 29 percent.

Chairman Allenby asked if there were any questions or comments. Mr. Sands asked Mr. Sanchez how the enrollment compares to the budget estimate. Mr. Sanchez stated MRMIB is well within the budgeted amount for the fiscal year. Ms. Cummings indicated that staff will present a comparison of budgeted vs. actual enrollment when it presents the Governor's budget proposal to the Board in January.

There were no additional questions or comments from the Board or the public.

Administrative Vendor Performance Report

Mr. Sanchez reviewed the monthly report performance report. The vendor met all contractual requirements for processing applications at single point of entry and the telephone line requirements. The vendor also met all of the quality and accuracy standards which will become contractual requirements for November transactions. Maximus is voluntarily reporting the standards presently. Chairman Allenby asked if there were any questions or comments. There were none.

Enrollment Entities/Certified Application Assistants Reimbursement Report

Larry Lucero reported on the amounts paid to enrolment entities for application assistance, the number of EE's and the number of CAA's participating. Dr. Chang asked if staff has a sense of the drop out rate of CAA's. The Board knows the number of new entities, but does not know the number dropping. Mr. Lucero indicated that he did not know the number, but thought it was very low. Janette Lopez said that staff contact EE's every other year to confirm their participating in the program. Dr. Chang thought a report on the number dropping off would be helpful. Ms. Cummings commented that the increased CAA reimbursements for use of the public application and assistance at annual eligibility review would be increasing retention and new participation.

Phases II and III Solicitation for an Evaluation of Plan Provided HFP Mental Health and Substance Abuse Services (Final)

Ruben Mejia reviewed with the Board comments staff had received on the Phase II and III solicitation since the Board reviewed the draft at the November meeting.

Three or four plans suggested discontinuing the SED carve out, noting various improvements in patient care that would result. However, the SED carve out was the subject of the Phase I part of the project which is now complete. Other comments were to clarify terminology and to study the measurement process.

Chairman Allenby asked if there were any questions or comments. Ms. Gotlieb asked Mr. Mejia to review the changes that were made to the solicitation since the last meeting. Mr. Mejia reviewed the changes. Dr. Crowell suggested an additional to address her longstanding concern that children with mental health needs were not being identified. She suggested the following: that item 6 on page 5 be revised to read: "Identify standardized mental health and substance screening tools in search for other methods that could be implemented in Healthy Families program to assure identification of all children needing mental health services."

Chairman Allenby stated this will be noted in the motion.

Now, therefore, be it resolved that the Board approves the solicitation with revisions and staff to finalize the documents.

Traditional and Safety Net Primary Care Physicians Report for 2005

Carolyn Tagupa reported on the number of HFP subscribers who selected traditional and safety net (T&SN) as their primary care physicians in calendar year 2005. Staff has presented similar reports for 2004 and 2002. On a go-forward basis, staff will alternate production of this report with the Healthy Families co-payment report, so the next report will be for 2007.

MRMIB allows the health plan in a given county that has the highest number of T&SN providers under contract to charge a lower premium in HFP. This is to provide plans with an incentive to include T&SN providers in their networks while leaving subscribers a broad array of choice. This report provides information on how many subscribers have chooses a T&SN physician as their primary care physician. In 2005, sixty two percent of HFP members received primary care services from T&SN providers a level consistent with prior years. Of note is that sixty percent of the subscribers selected their traditional and safety net provider while thirty nine percent of the members were assigned to the provider by their plan. A number of plans make provider assignments when a family fails to chose a provider on their application. The number of subscribers assigned to a TS&N provider has increased significantly from 2004 (the last year for which there is an analysis), up 20% from the 2004 level of 19%. (Ms. Tagupa noted that the report states an 18 percent change which is an error. The figure is 20 percent and staff will correct the report.)

Continuing with her presentation, Ms. Tagupa reviewed demographic differences in the selection. The only significant change in ethnicity or language spoken is

that the percentage of Vietnamese speakers with T&SN providers has increased from 60% in 2002 to 75% in 2005.

In discussing results with plans, several indicated that they are doing a much better job at capturing participation of T&SN providers than in the past. Also, Health Plan of San Mateo commented that the method used to generate the T&SN lists for the clinic and CHDP portion of the community provider plan (CPP process) uses data from fee for service claims. This method does not take into account that some T&SN providers are capitated. Health Plan of San Mateo thought that its score would be closer to 100% if capitated providers were included.

Ms. Tagupa emphasized this report looks at T&SN provider rates for primary care and does not capture examine the rates for specialty care. Ms. Tagupa also stated some plans, such as Kaiser or plans that do not use PCP's, do not report this information to MRMIB. Thus, T&SN participation is under-reported.

Chairman Allenby asked if there were any questions or comments.

Mr. Figueroa commented that fewer subscribers seemed to be selecting a T&SN provider up front, but more plans appear to be assigning them at the back end. Ms. Tagupa stated that she was not aware of the reasons for this change. Mr. Figueroa noted that there simply could be a lot more choices for subscribers that they are taking advantage of at the front end—and plans may by doing a better job making the linkage on the back end. And both of these things would be good. But a 20% change in the assignment rate is huge.

Dr. Crowell asked Ms. Tagupa why the Blue Shield HMO dropped from 40 percent in 2002 to 7 percent in 2004 and 2005. Ms. Tagupa indicated that she had reviewed the data with Blue Shield and the plan was not sure why this had changed.

Mr. Figueroa stated this could be directly correlated to more choice of providers. The Board discussed possible avenues for follow-up. Ms. Cummings stated the Board's policy has always been to ensure that subscribers have a choice of traditional and safety net providers but also wanting them to have a choice of other providers if that is their decision. At the end of the day, subscribers get to make the decision. Dr. Crowell asked if subscribers have the choice. Ms. Cummings replied they do—and the Board provides plans a financial incentive to contract with them (via the lower premium for CPP). Any report will provide opportunities to chase down data anomalies and the Board has to balance the need for purer data and understanding with other program information needs. Ms. Cummings emphasized that including T&SN providers in the program is important, but she thinks it is clear that they have substantial representation and that subscribers have a choice, consistent with Board policy.

Chairman Allenby complimented Ms. Tagupa on a good report and asked if there were any further questions or comments. There were no further questions or comments.

Health Plan Quality Measurement Report for Services Provided in 2005 (HEDIS)

Ms. Tagupa presented the report on program and plan performance on HEDIS measures for services provided in 2005 and provided an update on the foregoing report. She began by reviewing performance for the program as a whole with national scores for Medicaid and commercial business. HFP continues to compare well with national and statewide benchmarks. For 2005 services, staff analyzed seven HEDIS/utilization measures. These categories include: childhood immunization status; well-child visits for 3-6 year olds; adolescent well-care visits; children and adolescent access to primary care practitioners; follow up after hospitalization for mental illness; utilization of alcohol and other drug services, and; use of appropriate medications for people with asthma. Ms. Tagupa stated that MRMIB will discontinue use of the mental illness hospitalization measure and replaced it with a mental heal utilization measure.

She reminded the Board how MRMIB uses the HEDIS data. HEDIS scores are fed into an analysis called the Quality Performance Improvement Project (QPIP). Staff analyzes plan performance, looking not just at the most recent data but also at performance change over time. It identifies plans that are performing one standard deviation better or worse than the program average. Staff then follow-up with plans to learn from superior performers what contributes to success and work with lower performers to develop corrective action plans. Thus, the data in this report will be fed into a future QPIP report. Staff intend to incorporate results from the Consumer Assessment of Health Plans Survey (CAHPS) into the next report as well. The last QPIP report is available on the MRMIB website at (www.mrmib.ca.gov).

The program-wide childhood immunization score rose 7 percentage points to 82 percent higher than benchmarks for Medi-Cal and national commercial and Medicaid populations. The 65% score for well-child visits declined slightly and is less than the only available comparable measure—Medi-Cal. While the score for adolescent well-care is comparable for Medi-Cal (the only available benchmark), it continues to be extremely low at 36%. Children's access to primary care improved for every age cohort (no benchmark data). At 89%, the score for asthma medications was consistent with commercial and national Medicaid populations and higher than Medi-Cal.

Before reviewing performance by plan, Ms. Tagupa commented on the difference it can make to a plan score to conduct medical record reviews to confirm administrative data. The NCQA allows plans to use one of two methods for collecting data for measures. These include the administrative method and the

hybrid method. Scores using the hybrid method are generally higher. This method includes pulling records which is more labor intensive. Ms. Tagupa stated Blue Shield EPO for childhood immunizations is low at 7 percent. This appears to be the first year Blue Shield has reported quality performance measures for their EPO product. Blue Shield believes the low score results from use of the administrative method used to capture this information. Blue Shield does not believe that the cost of a medical record review is warranted for this product given its relatively low enrollment, but believes that the score would be higher if one were done. A number of other plans have chosen to proceed with the hybrid method despite similar enrollment levels.

Ms. Tagupa presented plan by plan performance by measure and then asked the Board for any questions or comments.

Ms. Gotlieb asked adolescent well care visits showed a score of 36 percent when scores for access to primary care physicians for Cohort 4 (ages 12-18) were at 81 percent. Ms. Gotlieb noted that the primary care access measure spans a two-year period, but wondered if that was a sufficient explanation. Ms. Tagupa suggested that the measures looked at two different types of visits, one a scheduled well visit and the other an urgent care visit. Ms. Gotlieb urged staff to continue working on ways to improve the well visit score.

Mr. Campana stressed the importance of developing a mindset of well care visits for adolescents. Early diagnosis is of tremendous value. He also pointed out that several plans (San Francisco Health Plan and Inland Empire's Health Plan), have made significant gains. He asked what MRMIB and other plans could learn from those with higher scores. Ms. Tagupa responded that this is exactly what the QPIP is about, learning from higher achievers and communicating successful methods to lower achievers. Ms. Cummings stated that Vallita Lewis, former Deputy in Benefits and Quality Monitoring, had conversations with all plans on this measure looking for ways to improve it. There was disagreement among the plans about how to proceed and staff is currently working on the follow up. Mr. Campana thanked Ms. Cummings and Ms. Tagupa.

Dr. Chang stated she did not exactly recall the timing of the change in the appropriate medications for the asthma score because the measures were changed. It may be that the Medi-Cal managed care 2004 score may not be appropriate because they changed the definitions of how they do the measure. Dr. Chang also pointed out the striking decline in scores for the childhood immunization measure for Latinos and Spanish-speaking persons. Dr. Chang suggested that staff may want to look at this decline not only by plan but also by region. There could be factors going on in some particular communities which warrant a public health intervention. Dr. Chang stated that the decline is disturbing.

Mr. Sands indicated that he thought there must be an error in the data. He noted that the overall score improved and it is difficult to understand how there could be an improvement overall when there was a significant decline in the score of the program's largest population (Latino's). Mr. Sands recommends that staff review and analyze the data again. Ms. Tagupa stated staff will look into this request and thanked Mr. Sands.

Mr. Figueroa asked how and when the public accesses the data. Ms. Cummings replied that it is available in the program handbook and on MRMIB's website.

Chairman Allenby asked if there were any further questions from the Board or the public. There were no further questions or comments.

Community Provider Plan Update

Ms. Tagupa informed the Board that the final traditional and safety net providers listings used to determine the community provider plan (CPP) had been sent to the plans on December 15th. Plans have until January 15, 2007 to provide their updated listings. Chairman Allenby asked if there were any questions or comments. There were none.

CHILDREN'S HEALTH INITIATIVE MATCHING FUND (CHIM) UPDATE

Buy-In

Sarah Swaney advised the Board what staff has done on the CCS issue since the last meeting and what is coming up over the next several months. Staff has spent a great deal of time in the last several months researching the reinsurance issue to reinsure the risk of CCS conditions for children not CCS eligible. The CCS issue has created delays in implementing the Buy-In which cannot proceed until the issue is resolved.

At the time of the last Board meeting, staff had obtained a quote on reinsurance from one reinsurer--Ace American. Since then, staff has received a quote from One Beacon. She indicated that staff was very happy with the quote.

Ms. Swaney presented a comparison of the two quotes to the Board. Mr. Figueroa asked whether One Beacon's bid capped the reinsurer's risk at $1,000,000. Ms. Swaney replied that it did. Mr. Figueroa then asked whether the fact that One Beacon did not provide bids for $200,000, $175,000 and $100,000 risk levels made the bid more or less attractive. Ms. Swaney cautioned that these were initial bids and staff intended to discuss the bids further with the bidders. Mr. Figueroa opined that he didn't think the reinsurers had a good understanding of the program when deciding to bid, that it was completely new territory to them. Ms. Lopez stated that staff had tried to educate them and give

them some parameters. One critical parameter is that MRMIB told them to assume that the risk would be spread over 20,000 children. Mr. Figueroa stated this helps. Ms. Swaney stated as staff goes into next month in terms of gathering information from the counties it could be the 20,000 will increase and quotes may change.

Ms. Swaney indicated the following next steps: Staff will consult with the plans that would be providing service in the Buy-In counties to ascertain whether the re-insurance approach addresses their concerns about participation. Staff will also be surveying counties to ascertain and re-confirm interest. Staff sent out a survey to counties yesterday and will be having a conference call with them on January 18.

Ms. Swaney noted that MRMIB has received several letters in the last few months-one of which was from the Children's Specialty Care Coalition and another letter recently from Family Voices of California. Both organizations are very interested in ensuring that the Board provides services to ineligible children through the CCS delivery system, arguing that the children should have access for treatment of CCS conditions to the excellent specialty network CCS provides. Staff will continue discussions with Children's Specialty Care Coalition and Family Voices of America.

Staff also will continue discussions with Health Net regarding reinsurance data that Health Net offered at the November board meeting.

Chairman Allenby asked if there were any questions or comments. There were none.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Mr. Sanchez reported that in the month of November 951 mothers enrolled, bringing the fiscal year total to 4,836. Currently there are 7,283 women enrolled in the program. The ethnicity breakdown has not changed significantly.

Chairman Allenby asked if there were any questions or comments. There were none.

Administrative Vendor Performance Report

Mr. Sanchez informed Board that the vendor met all requirements.

Chairman Allenby asked if there were any questions or comments. Ms. Gotlieb commented that it is impressive to see that the vendor's telephone line had a 0% busy rate. There were no further questions or comments.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Mr. Sanchez reviewed the enrollment report. In the month of December, 308 new subscribers enrolled, bringing the current total to 7,800 enrolled subscribers. The enrollment cap is presently at 9182 and there is no waiting list currently. Chairman Allenby asked if there were any questions or comments. There were none.

Administrative Vendor Performance Report

Mr. Sanchez presented the performance report. The vendors met all standards. Chairman Allenby asked if there were any questions or comments from the Board or the public. There were none.

Federal Seed Grant Implementation Update

Ms. Cummings indicated that she had received only two comments on the MRMIB Benefit Plan Review document reviewed at the Board's November meeting. Blue Cross indicated that the review was going in the right direction. However, it continues to be concerned about the use of a deductible in a high risk program. The deductible increases overall program costs. Kaiser noted that it has an elaborate disease and case management and prescription benefit management program that has been developed for their entire book of business. Kaiser does not do anything special for MRMIP subscribers but instead provides them with services consistent with those provided to all other Kaiser subscribers. Kaiser was not enthusiastic about any idea that would cause them to change their practices.

Kaiser also commented that if the Board decides to provide high deductible coverage through MRMIP, the present method of constructing subscriber premium would not be adequate to address the different distribution of risk that would results. Ms. Cummings explained how MRMIP rates are set stated presently, withholding comment for now on the argument Kaiser presented.

Ms. Cummings reviewed changes to the document made since the presentation at last month's board meeting, noting that they are underlined in the document. Chairman Allenby called for questions or comments. There were none.

There being no further business to come to the Board, the meeting was duly adjourned at approximately 12:25pm.